

**PEDIATRIC VISIT 9 to 11 MONTHS**

DATE OF SERVICE \_\_\_\_\_

NAME \_\_\_\_\_ M / F DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

WEIGHT \_\_\_\_\_ / \_\_\_\_\_ % HEIGHT \_\_\_\_\_ / \_\_\_\_\_ % HC \_\_\_\_\_ / \_\_\_\_\_ % TEMP \_\_\_\_\_

**HISTORY:**

Family health history documented &amp; updated? \_\_\_\_\_

Perinatal history documented &amp; updated? \_\_\_\_\_

Reactions to immunizations? Yes / No \_\_\_\_\_

Concerns: \_\_\_\_\_

**PSYCHOSOCIAL ASSESSMENT:****Sleep:** \_\_\_\_\_ **Child care:** \_\_\_\_\_**Recent changes in family:** (circle all that apply)

New members, separation, chronic illness, death, recent move, loss of job, other \_\_\_\_\_

**Environment:** Smokers in home? Yes / No**Violence Assessment:**

History of injuries, accidents? Yes / No

Evidence of neglect or abuse? Yes / No

**RISK ASSESSMENT: TB (Annual) LEAD**

(Circle) Pos / Neg Pos / Neg

**PHYSICAL EXAMINATION:**

Wnl	Abn	(describe abnormalities)
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Head/Face
<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Red reflex/Cover test
<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Dentition (# of teeth)
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	Extremities/Hips/Feet
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes/Tone
<input type="checkbox"/>	<input type="checkbox"/>	Vision (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing (gross assessment)

**NUTRITIONAL ASSESSMENT:****Breast/bottle:** Amount & frequency \_\_\_\_\_**Bowel/bladder:** Number of wet \_\_\_\_\_, dry \_\_\_\_\_ in 24 hours?  
Number BM's in 24 hours? \_\_\_\_\_**Education:** Jar/table foods ☐ Offer cup ☐ Avoid small hard foods ☐  
Encourage self-feeding/finger foods ☐ Expect messiness/playing with food ☐ Water only bedtime bottle ☐**DEVELOPMENTAL SCREENING:** (With Standardized Tool)  
**REQUIRED****ASQ:** ☐ **PEDs** ☐ **Other:** ☐ (specify) \_\_\_\_\_**Results:** Wnl ☐ **Areas of Concern:** \_\_\_\_\_**Referred:** Yes / No **Where?** \_\_\_\_\_**DEVELOPMENTAL SURVEILLANCE:** (Observed or Reported)**Social:** Shy with strangers ☐ Plays patty cake ☐Looks for fallen object ☐**Fine Motor:** Bangs two cubes ☐ Pincer grasp ☐ Reaches, grabs ☐ Feeds self ☐ Drinks from cup ☐**Language:** Dada or Mama (specific) ☐ Babbles ☐Imitates speech sounds ☐**Gross Motor:** Gets to sitting ☐ Pulls self to stand ☐**ANTICIPATORY GUIDANCE:** (Check all that were discussed)**Social:** Fear of strangers ☐ Separation anxiety ☐**Parenting:** Emphasize protection over discipline ☐Temper tantrums: ignore, distract ☐ May need reassurance for separation anxiety ☐**Play and communication:** Water and sand play ☐ Toys with moving parts, holes, strings to pull ☐ Beginning speech sounds ☐**Health:** Fluoride if well water ☐ Second hand smoke ☐Clean teeth with soft toothbrush or cloth ☐ Use sunscreen ☐**Injury prevention:** Rear riding/rear facing infant car seat ☐Smoke detector/escape plan ☐ Poison control# ☐Hot liquids ☐ Hot water set at 120° ☐ Water safety (tub, pool) ☐Choking/suffocation ☐ Firearms (owner risk/safe storage) ☐Fall prevention (heights) ☐ Baby proof home ☐Don't leave unattended ☐**PLANS/ORDERS/REFERRALS**

1. Immunizations ordered ☐ \_\_\_\_\_
2. Lead test referral (if positive risk assessment) ☐ \_\_\_\_\_
3. Fluoride Varnish Applied? Yes / No \_\_\_\_\_
4. Next preventive appointment at 12 months ☐ \_\_\_\_\_
5. Referrals for identified problems? (specify) \_\_\_\_\_

Signatures: \_\_\_\_\_